APP-114
614.547
A427s

A STUDY OF SEXUAL BEHAVIOR, SEX INFORMATION AND SELF-CONCEPT IN ADOLESCENT VENEREAL DISEASE PATIENTS

A RESEARCH REPORT
PRESENTED TO THE FACULTY OF
THE RAYMOND A. KENT SCHOOL OF SOCIAL WORK
UNIVERSITY OF LOUISVILLE
IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
MASTER OF SCIENCE IN SOCIAL WORK

Joan Allen
Ralph H. Childers
Hubert Crawford
Olin Gentry, Jr.
Ralph Hollon
Carol Hill
Evelyn J. McKissick

APPROVED:

Frank M. Vecchy
Research Professor

Kenneth W. Kindelsperger
Dean

June, 1965

ACKNOWLEDGEMENTS

We gratefully acknowledge the assistance of the following people who helped to make this study possible:

Professor Frank M. Vicroy, Ph. D., Head of the Sociology Department, and Lecturer for Raymond A. Kent School of Social Work, University of Louisville.

Dr. Lawrence Clare, M. D., Director, Specialty Clinic, United States Public Health Service, Louisville, Ky. and his Staff.

Mr. Robert Sanders, Ed. D., Director of Pupil Personnel, Louisville Public Schools, Louisville, Kentucky.

Mr. William Clem, Principal, Shawnee High School, Louisville, Kentucky.

Dr. Walter Reckless, Ph. D., Ohio State University, Columbus, Ohio.

TABLE OF CONTENTS

		Page
ACKNOWLEDGEMENTS.		ii
LIST OF TABLES.		iii
CHAPTER		
I.	INTRODUCTION.	1
	Statement of the Problem Purpose of the Study Survey of Literature	
II.	METHODOLOGY, SCOPE AND LIMITATIONS.	14
	Statistical Procedure	
III.	RESULTS OF DATA ANALYSIS AND CONCLUSIONS. . . .	23
IV.	RESULTS AND CONCLUSION OF PERSONAL INTERVIEWS. .	35
V.	SUMMARY, DISCUSSION, AND RECOMMENDATIONS FOR FURTHER RESEARCH.	40
APPENDIX I		
	Selected Case Interviews.	51
APPENDIX II		
	Schedule A. A - 19 and Under.	63
	Schedule B. C - 19 and Under.	74
APPENDIX III		
	Data for Males and Females Within the Experimental Group.	78
BIBLIOGRAPHY.		89

LIST OF TABLES

Table Page

I. Favorableness of Self-Concept Experimental and Control Groups. 23

II. Favorableness of Self-Concept By Sex Experimental Group. 24

III. Favorableness of Self-Concept By Sex Experimental Group. 25

IV. Self-Concept By Age, Males, Experimental Group. . . . 25

V. Self-Concept By Age, Females, Experimental Group. . . 26

VI. Person(s) Lived With By Type of Group. 26

CHAPTER I

INTRODUCTION

Two of the venereal diseases, syphilis and gonorrhea, have not been brought under control anywhere in the world. In the United States intensive efforts to find, treat, and prevent venereal disease have been actively underway since 1936. The Public Health Service estimated in 1962 that perhaps 60,000 cases of syphilis and 1,000,000 or more of gonorrhea occur each year in the United States. Of these, approximately 8,000 of the syphilis cases and 237,000 of the gonorrhea cases were actually reported.[1] The upward trend is particularly noticeable in the teenage population. In the age group fifteen to nineteen years there was a 135.8% increase between the years 1956 and 1960 in the cases of primary and secondary syphilis. In this same age group for the same period of time there was a 21.2% increase in gonorrhea.[2] Gonorrhea is the disease with which we will be concerned in our study as it afforded a sufficient volume of patients from which to draw a significant sample.

In the 1940's, penicillin revolutionized treatment of venereal disease. As part of the wave of over-optimism that followed, public health funds were cut and educational efforts were all but abandoned, resulting in reliance on miracle drugs to eradicate venereal disease.

---

[1]Richman, T. Leroy. Venereal Disease, Old Plague-New Challenge, Public Affairs Pamphlet No. 292, New York.

[2]A Task Force Report to the Surgeon General, U. S. Department of Health, Education, and Welfare. The Eradification of Syphilis. 1960.

Efforts to inform children, adolescents, or adults about venereal disease and its potential to maim, blind, produce insanity, damage or destroy unborn children, cause sterility, and even death were reduced. In spite of wonder drugs, the incidence of syphilis and gonorrhea has risen, particularly in teenagers and young adults. In 1958, twenty-two states and thirty-one major cities reported increases in venereal disease among their fifteen to nineteen year olds. In 1959 the estimate indicated that the United States had an annual infected teenage population of about 200,000.[3] Over half the venereal disease caseloads in our public health clinics throughout the country are teenagers and young adults.[4]

A study in New York City in 1959 showed that ninety-seven of the city's three hundred-fifty two health areas, which held 27% of the city's population, were responsible for 51% of all juvenile offenses, 73% of all Aid to Dependent Children, 45% of all infant mortality, 71% of all venereal disease, and 41% of all psychiatric clinic cases.[5] However, teenage venereal disease is no longer confined to slum neighborhoods or to juvenile delinquents; it is invading all socio-economic levels.

Sexual promiscuity is basic to the spread of venereal disease. This very factor, with all its social, moral, psychological, legal, and medical connotations, separates venereal disease in the minds of many from other communicable diseases, thus contributing to the

---

[3]Bird, Robert S., "VD is Still a Teenage Problem," Parents Magazine, October, 1959.

[4]Richman, T. Leroy, op. cit.

[5]"Interaction of 'VD' and Other Social Problems", Youth Board News, New York, May, 1959.

difficulty of both detection and control. Venereal disease is usually clandestinely contracted. Understandably, the last thing the patient desires is public disclosure of his disease and how he acquired it. Contacts (those whom he infected) share similar apprehensions--apprehensions which are particularly accentuated when premarital, extra-marital, or homosexual relations are involved. (It is interesting to note that the homosexual often has an erroneous belief that venereal idsease can be transmitted only through heterosexual relations, and he seldom sees the need for venereal disease examinations. Added to this fact, the homosexual seldom is willing to incriminate himself or his contacts by reporting it since this could mean police arrest.)

Dr. Fiumara, in reporting an outbreak of gonorrhea in Massachusetts, has stated that, as long as our sexual mores remain as they are, and as long as there is an infectious reservoir in the community, cases of venereal disease are bound to occur. There likely will be actual outbreaks or epidemics as these missed or undiagnosed infectious cases add to this resevoir. Whether the reservoir will be controlled depends on the vigilance of the medical profession and the availability of organized venereal disease control services.[6]

State Health Departments have the primary responsibility in their states for the development and coordination of venereal disease programs. A large city is likely to operate its own control program--such as in Louisville at the General Hospital Specialty Clinic where

---

[6]Fiumara, Shinbert, Byrne, and Fountaine, "An Outbreak of Gonorrhea and Early Syphilis in Massachusetts." New England Journal of Medicine,

anyone may receive treatment without charge. All cases of syphilis and gonorrhea are required to be reported to the State Health Department in every state. These reports are used to initiate contact investigations--that is, seeking out by case investigators of all the sexual contacts of a particular venereal disease patient. In most states any person known to have venereal disease, or even suspected to be a sexual contact of such an individual, is required by law to seek medical care either from a private physician or the local health department for examination and treatment. The examination must include a serological test, a smear for gonorrhea, and any other tests ordered by public health authorities. All reports and records are confidential. Essentially then, local, state, and national public health agencies work together. They form a network for the control of venereal disease through diagnosis, reporting of cases, treatment of cases, interviewing of patients, investigation of contacts, and educational measures.[7]

Still, in spite of many advances in the detection and treatment of venereal disease, the rate increases. Some public health authorities feel that one weakness in control is inadequate reporting by private physicians. Most authorities give a 10% figure as an estimate of total reported cases of gonorrhea.

There are many other theories advanced as playing major roles in the increasing incidence of venereal disease--loose morality in adults, permissiveness in teenagers, transiency of migrant workers,

---

[7] A Guide for Teachers, Venereal Disease Education, Kansas State Board of Health, 1962.

little or no sex education in the home, taboos regarding sex, prejudicial attitudes, ignorance, apathy, increased promiscuity, family instability, neurosis (acting-out, primarily), relative ease in securing treatment, and little or no opportunity for teenagers to learn their feminine or masculine roles.

Safier et al., in a study not concerned directly with venereal disease but with promiscuity, noted the importance of conflict and frustrations of neurosis and unsatisfactory familial relationships--all predominant factors which appeared to have a direct relationship to promiscuous behavior. They also felt that environmental factors, such as unsatisfactory living conditions, absence of community ties, and the making of casual friendships, contributed to the rise in promiscuity.[8] A California study summarized their findings as follows:

> ".........it appears that repeated venereal disease infections in males at least, is frequently associated with two chief stereotypes: 1) low levels of intelligence, education, skills, and sophistication; and 2) neurotic individuals of higher education and sophistication who are promiscuous as the result of prolonged egocentricity. The neurotic personality, who is unable to sustain long-term relationships, substitutes sexuality for affection, cannot be deterred by repeated infections of venereal disease. The records of every venereal disease clinic support this position and at the same time should emphasize the need for stronger efforts to rehabilitate these persons...Nothing less than intensive activity to promote sound levels of family living can hope to break the vicious cycle."[9]

In our study it will only be possible to delineate certain problem areas and suggest the complexities and ramifications of venereal disease and sexual promiscuity as these relate to the adolescent. He

---

[8]State Department of Public Health, California Health Department Survey, Dec. 1, 1963, p. 82-83.

[9]Ibid.

is not an isolated entity but a complex human being and must be considered as such in all his roles and functions in life. Only if we see him as an individual in his environment, not a symptom, and learn how he sees himself, can we begin to be of any help in unsnarling the web of problems and circumstances in which this disturbed adolescent is entangled.

Before elaborating on the purpose and focus of our study, we wish to present some background material concerning the disease itself. Gonorrhea has apparently existed since prehistoric times. Hippocrates, in 460 B.C., was aware of it. Galen, in 200 A.D., introduced the name which was based on the belief that the discharge produced by the disease was an involuntary flow of semen (gonos--"seed," rhoia, - "flow"). Its relation to sexual intercourse was not understood until many years later. In 1790 gonorrhea was differentiated from syphilis and in 1831 this difference was authenticated. The actual isolation of the causative organism--the gonoccus--was made by Neisser in 1879.[10]

Gonorrhea is transmitted principally by sexual intercourse between men and women, but often by homosexual practices. Occasionally an infected mother transmits the disease to the eyes of her new baby as he passes through the birth canal. As with syphilis, gonorrhea is a venereal disease because the organism requires a moist area to be effectively transmitted from person to person.[11]

---

[10] Encyclopedia Britannica, Vol. 23, 1965, pp. 40-47.

[11] Kansas State Board of Health, op. cit.

In men, the first symptom of the disease is often a burning pain during urination a few days after exposure. The pain is usually followed by infectious discharge. These symptoms usually are sufficiently distressing to induce the patient to seek medical treatment. If endured, however, they may disappear without treatment after two or three weeks, leaving the disease to proceed unnoticed with a devastating invasion of the testicles and prostate gland. A woman almost never notices any pain or other symptoms in the early stages of gonorrhea. Her first sign of illness may not come until the disease has seriously damaged her reproductive organs. As there is no practical blood test for gonorrhea, diagnosis is made through microscopic examination of the infectious discharge. Like syphilis, most early cases of gonorrhea can be cured quickly and easily with penicillin or other antibiotics. If untreated, the disease can cause sterility, heart trouble, arthritis, blindness, even death.[12]

PURPOSE OF THE STUDY. We wish to examine the expressed self-concept of a sample of adolescents (ages fourteen--nineteen) being treated for gonorrhea at the Louisville General Hospital Specialty Clinic and compare this with the expressed self-concept of an adolescent school group, reflecting as nearly as possible similar age, sex, race, socio-economic class, and place of residence. This is done through a self-administered questionnaire. In the adolescent group with venereal disease (experimental group), we will further attempt to ascertain their sexual attitudes, knowledge and behavior, and their

---

[12]Terry, Luther. "VD's Alarming Comeback", Look Magazine, Dec. 4, 1962. Cowles Magazines and Broadcasting, Inc.

knowledge of venereal disease. A personal interview schedule was administered individually by the authors to secure this information. The section of the schedule relating to personal and social history of the patient was administered to the school group (control group). No attempt was made to report the control group's sexual behavior patterns or to determine if they had ever been clinic patients or treated elsewhere for venereal disease. Their status as public school students prohibits such inquiries.

During adolescence, the continuing development of ego identity is more and more concerned with sex-role identification. If the earlier stages of egocentricity have not been satisfactorily resolved by reciprocal love relationships with his parents, the adolescent enters adulthood with difficulty in establishing sustained love relationships. The urge to continue to try to achieve the unattainable persists, often with increasing frustration.[13]

Perlman describes a person's life-history as "his experience of interaction with people and circumstances which, for the most part, nurtured and exercised his sense of adequacy and mastery, or which mostly starved or inhibited that sense."[14] The adolescent we see may be one who has not only experienced severe discontinuties and haphazard patterns of early rearing, but in his present life may also have a sense of vagueness, rootlessness, and a sort of resigned apathy toward his world. Added to the usual inner questionings of

---

[13]Witthower, E.D., "The Psychological Aspects of Venereal Disease", British Journal of Venereal Diseases. 24:2, July, 1948.

[14]Perlman, Helen Harris, "Identity Problems, Role, and Casework Treatment", Social Service Review, Vol. 37, No. 3, Sept. 1963, p. 310.

the adolescent, about his own self-concept, his strivings and goals, plus the struggles facing such a person in a minority group, we expect to find many problems pervading all aspects of our patient's life.

While sexual promiscuity fosters the spread of venereal disease, it is itself the end result of many converging factors. As social workers, we must take into consideration not only our exploration of this patient's self-concept and the various sexual attitudes and behavior he exhibits, but also must realize that he represents a serious symptom of family and community failure. The challenge is tremendous. These patients, with their deprived upbringing facing what they feel may be an unsympathetic world, may hold quite uncritical, submissive, and hopeless attitudes toward their lot. They may exhibit little concern with the psychological side of life--the inner world of motivation, subjective experience, and aspiration.

Epstein, in studying the self-concept of delinquent females, concluded that the delinquent's portrayal of self-image indicated a highly negativistic and personalized image of self and future goals, setting her apart from her peers whose image was positive and defined in terms of social groups and role identifications, as were their goals.[15] Deitche, in a study of delinquent and non-delinquent boys, found that there was a statistically significant difference between two groups in terms of self-concept. The non-de-

---

[15]Epstein, Elenor M. "The Self-Concept of the Delinquent Female", Smith College Studies, Vol. 32, pp. 220-234.

linquents were more positive in their self-concepts, but there was no statistically significant difference in the consistency of the responses in the non-delinquent group.[16] Purcell, in a similar study of expressed self-concept and adjustment in sexually delinquent and non-delinquent girls, found that the delinquent had a poorer self-concept.[17] Milner, in her study of the effects of sex role and social status on adolescent personalities, suggests that the major sex-delineated characteristics of the adult have already been established by early adolescence.[18]

Much of the literature we have surveyed has been directed toward ascertainment of female adolescent self-concept related to delinquent female adolescents. Nonetheless, these studies remain pertinent to our inquiry into the self-concept of the adolescent patient with venereal disease, if for no other reason than to support the need for examining self-concept in adolescents exhibiting other problems--male or female and especially among the venereal disease patients. Although the adolescent in this study are not considered delinquent at least by expressed middle-class values, they could be considered as engaging in socially-deviant behavior (defined as behavior in the middle-class value--orientation to which our society at least verbally subscribes). Let us hasten to add

---

[16] Deitche, John H., "The Performance of Delinquent and Non-Delinquent Boys on the Tennessee Department of Mental Health Self-Concept Scale," Dissertation Abstracts, Vol. XX, Oct. 1959, No. 4, pp. 1437-1438.

[17] Purcell, John F., "Expressed Self-Concept and Adjustment in Sexually Delinquent and Non-Delinquent Girls," Dissertation Abstracts, Vol. 22 July-September, 1961, p. 913.

[18] Milner, Ester, "The Effects of Sex Role and Social Status on Early Adolescent Personality", Genetic Psychology Monograph, No. 1949, Vol. 40, The Journal Press, Provincetown, Mass.

that we are not placing value-judgement on middle-class behavior as "good".

It is interesting to note that a study by Ball and Logan, related to the sexual behavior of lower-class delinquent girls, found that these girls verbally upheld the principle of chastity. They did not believe in premarital sexual relations in the abstract, believing such actions to be deviant and not socially acceptable.[19]

As we examine each individual patient's personal feelings about his sexual behavior and discuss with him the various questions in our interview schedule, we must understand the impact of the interview situation itself. We may find that few of these patients have ever been able to talk freely with any trustworthy adult about his shame, guilt, apprehension, or other feelings he may have about contracting a venereal disease. We will be interested in many other questions: How stable are their families? What is the extent of their promiscuity? How do they feel about having venereal disease? Do they engage in promiscuous sexual behavior (and, if so, to what extent)? How would they interpret facts about sex and venereal disease to their own children? To what extent are their actions in conflict with their own religious or ethical beliefs or those of their families or associates? To what extent is their behavior an accepted part of their cultural milieu? What are their friendship and leisure time activity patterns? Are they anxious, panicky, upset, resigned, or apathetic about their problems? Above all, what can we as social workers, learn from our casework interviews? Have we stereotyped these patients? Can we

---

[19]Ball, John C. and Logan, Niel. "Early Sexual Behavior of Lower-Class Delinquent Girls," Journal of Criminal Law, Criminology and Police Science, Vol. 51, No. 2, July-August, 1960, pp. 212-213.

elicit their true feelings--what they think about themselves, what they think others feel about them, and what they want for themselves? Can they verbalize their feelings?

The importance of the caseworker cannot be stressed enough. As Perlman so eloquently phrases it,

> ".....the sense of self expands when, as in a casework interview, the client is accepted, affirmed, and then supported as he learns to perceive and modify his feelings and actions. His rewards for trying to see himself more clearly, to share his feelings, to modify his behavior lie in his sense of mastery when he succeeds, in the caseworker's unflagging encouragement when he fails, and in the responses and recognition he gets from other persons involved with him...Sometimes caseworkers feel sad because they cannot give enough to make up for all the deficiencies of social and psychological nurture from which many clients suffer. Even the most intensive therapies cannot achieve this. But within the boundaries of our roles as caseworkers...we can set in motion a chain of changing attitudes and behaviors which may nourish selfhood. The sense of self, of identity, grows on the effective use of one's small powers in relation to other people and things....When a caseworker helps his client find himself adequate in relation to love and work-tasks, he builds into that person's sense of personal identity and social worth."[20]

But what of the future of our patients? The ease and speed of treatment have relegated gonorrhea in the minds of many to the rank of a minor nuisance. Repeated reinfections will continue to occur. In fact, venereal disease may not be controlled in our time. Control will depend certainly on more vigorous execution of present programs--diagnosis, treatment, casefindings, education. More adequate reporting procedures, especially by private practitioners, must be instigated and required. But not until we can reach the

---

[20]Perlman, Helen Harris, op. cit., pp. 317-318.

individual patient (realizing all the while that families, communities, and agencies must bear their responsibility for the problem) and understnad him uniquely will we ever begin to make a significant dent in the wall which impedes progress. We caseworkers have the ability to do this--and we must begin somewhere--soon.

In the experimental group, we focused on finding out their self-concept and attempted to delineate some sexual behavioral characteristics or patterns of this group. Specifically, we will attempt to test the following hypotheses:

(1) The mean self-concept score of the experimental group will be significantly less favorable than the mean self-concept score of the control group.

(2) The mean self-concept score of the males will be more favorable than the score of the females in the experimental group.

(3) It is generally hypothesized that there will be differences between males and females within the experimental group with respect to certain characteristics of sexual behavior.

This control group was taken from Shawnee High School population, ninth through twelfth grades, which reflected as nearly as possible the same socio-economic status (the majority of the experimental group, according to the census tracts, fell within the geographical area of the school district) and proportion of age, sex, and race as the experimental group. It will be assumed that no member of this group has or has had venereal disease. One of the limitations of the study is that the names in the control group could not be run through the Clinic, as the school authorities would not furnish the names of the respondents. It is possible that some members of this group have received treatment for venereal disease by a private physician. However, since their socio-economic status is relatively the same as the experimental group, this latter possibility is considered remote.

As in the experimental group we focused on the self-concept so as to provide a mode of comparability between the two groups in terms of the aforementioned hypothesis.

No attempt was made to delineate the control group's sexual behavior patterns or knowledge about venereal disease and sex since their status as public school students prohibits such an inquiry.

Two instruments were used in the study, (one) a self-administered questionnaire which was given to both groups to measure the self-concept of the group members. This instrument was originally developed by Reckless, et al.,[22] to measure self-concept of sixth grade school children, but could be used to measure the self-concept of older adolescents. This questionnaire consists of thirty-two items. The sixteen even numbered items are scored so that a high total score represents an unfavorable self-concept and conversely for a favorable self-concept.

The authors developed a questionnaire which incorporated the Reckless questionnaire. This questionnaire contained seventy-seven questions divided into four parts. During the nine weeks of pretesting, which took place from October 11, 1964 to December 4, 1964, the questionnaire was revised three times in order to obtain clarity. For the pretest, the questionnaire was administered to all patients, regardless of age, who came to the Clinic for treatment of venereal

---

[22]Reckless, Walter, et al., "The Self-Concept as an Insulator Against Delinquency," American Sociological Review, Vol. 21, No. 6, December 1956, pp. 744-746.

disease. Many of these patients were also interviewed.

We did not pretest the control group.

The cover sheet design was prepared in a manner consistent with the Specialty Clinic's policy of maintaining confidentiality of its clients. Space was provided for a number, which was assigned to the respondent by the nurse, thus eliminating the need for including the respondent's name and address. Checking the number with the files could later determine the respondent's address which the authors felt was indicative of the socio-economic status of the respondent. The cover sheet gave the number of the questionnaire, the number assigned to the respondent, the age of the respondent, the date of the interview, the interviewer's name, and general directions.

The questionaire, Form A-19 and Under, was administered to the experimental group (see appendix). Form C-19 and Under was administered to the control group (see appendix).

The four-part questionnaire consisted of the following sections:

Part I included identifying information such as marital status, with whom the respondent was living, and religious preference.

Part II consisted of questions regarding education and employment. It attempted to ascertain the grade in school the respondent had completed; the age at which he quit school or planned to quit; if working, the type of work in which he was engaged; and whether he was working full or parttime.

We also attempted to learn where the respondent ate supper.

This was an attempt to determine congeniality of family since the middle class values adhere or subscribe to the ritual of the family gathering around the supper table for the evening meal. Coming home for the evening meal with the family has the effect of setting limits on the family members; thus an established pattern of conformity would indicate esteem or regard held by the individual member for other members of the family. Does the adolescent have a place (home) which provides an atmosphere of belonging and security to which he can return after school or work, or is he adrift, wandering aimlessly with no place to go where he can feel wanted, appreciated and loved?

The number of close friends the respondents had and whether their friends were older or younger and of the same or opposite sex was also sought. It is theorized that adolescents occasionally are seduced into sexual promiscuity or sexual deviant behavior by older irresponsible adults. Too, it is known that the peer group is held in high esteem at this time and there is tremendous pressure to conform or achieve. Question Number 17 was designed to determine how the respondent usually spent his spare time.

Part III was aimed at determining the respondent's knowledge of sex, the source of his sex knowledge and information, age at which he had his first sexual experience, why sexual intercourse usually occurred, and whether any money was involved. In an effort to determine attitudes toward premarital sexual relations, he was asked why he engaged in sexual relations, and whether sexual acti-

vities outside of marriage were contrary to any beliefs that he held.

There is a commonly held belief that promiscuity contributes to the incidence of venereal disease. A question was asked in order to determine how many different sex partners the respondent had had in a one month period, the number of times he had sexual intercourse in a month, and whether or not sexual intercourse was enjoyed.

Part IV was designed to determine the respondent's knowledge of venereal diseases, how it is contracted, and how it is treated. To determine the respondent's attitude toward venereal disease, he was asked to give his reaction and his friend's reaction when he learned he had been exposed to venereal disease. He was asked whom he should tell about his problem and how many times he had been treated at the Clinic. The question was asked, "Would you like to be able to talk freely to someone you can trust about this problem?" This was done to determine the felt need for a caseworker at the Clinic.

The administration of the questionnaire to the experimental group and the personal interview with each member of this experimental group was conducted immediately after the patient's examination by the Clinic physician but prior to his treatment. The authors feel that this was the most strategic point in the clinical process to obtain the patient's optimum cooperation as the individual had yet to receive the treatment for which he had come to the Clinic and consequently continued to be in a state of stress.

The Clinic nurse referred the patient to one of the authors who was waiting in an interviewing room provided by the Clinic. The interviewer introduced himself to the patient in the following manner: "How do you do. My name is Mr., Mrs., or Miss______. The Federal Government is making a study of venereal disease in an effort to control this problem. We are asking your cooperation in completing this questionnaire. When you have completed this questionnaire you will be given an opportunity to verbally express your views and feelings about this problem and to ask any questions that you may have. You will note the questionnaire does not have a place for your name or your address. There are no right or wrong answers. Please be assured that we are <u>not</u> interested in identifying you but only in receiving your true thoughts about this problem as a part of the study. Your cooperation in this study is greatly appreciated."

When the questionnaire was completed, the interviewer held a less structured personal interview with the patient to gain more depth in certain aspects covered by the questionnaire. The following outline was used.

I. Note your impression of the individual:

1. Personal description; e.g., physical appearance, dress, speech.
2. Mannerism, include emotional state; e.g., is he tense, relaxed, cocky, etc.

II. The individual's self-concept:

1. Have the person describe himself; i.e., tell what he thinks of himself, his aspirations, goals and objectives in life.
2. How does he think others view him, feel about him?

3. What does he want to become, to do in life?
4. What does he think of others who get venereal disease, (hopefully he will reveal something about himself in answering this one).

III. Sexual behavior patterns, knowledge of venereal disease, and how this knowledge is acquired:

1. How his free or spare time is utilized.
2. Circumstances under which subject engages in sexual relations:
   a) time
   b) place
   c) frequency
   d) number of different partners
   e) if subject were married and had children would he object to their having premarital relations? Why?
3. How does subject feel about having venereal disease?
4. Where and how was knowledge of venereal disease acquired?
5. From whom did subject learn about sex? At what age?
6. Would he marry someone who has or has had venereal disease?

The patient was then referred back to the nurse for the completion of the clinical treatment.

There was some difficulty encountered in providing continuous coverage of the Clinic. The authors were unable to be present on Mondays and Tuesdays when the majority of the patients came in as they were on field placements these days. The Clinic was only covered on Wednesday from 1:00 P.M. to 4:30 P.M., on Thursdays from 10:00 A.M. to 2:00 P.M., and Fridays from 1:00 P.M. to 2:00 P.M. It was necessary to cover the Clinic during the Christmas holidays to obtain the desired sample.

Arrangements were made with school officials to administer Form C-19 and Under to a school group. The control group was drawn from the school population of Shawnee High School. This school was selected because, as shown by the comparison of census tracts, the

respondents in the experimental group live primarily in the area of the Shawnee High School district. One-hundred fifty students age thirteen through seventeen years inclusive, were selected by the school officials. Form C-19 and Under was administered to these students by the Assistant Principal under the supervision of the authors. From the one-hundred fifty completed questionnaires, the control group of thirty-four was drawn. It was matched with the experimental group on the basis of sex, race, and age. It was assumed that the control group was similar to the experimental group in socio-economic status because of the matching of census tracts. There was a limitation as far as matching the ages of the two groups. The mean age of the experimental group was 17.06 years and the mean age of the control group was 15 years.

Our proposed hypothesis relative to the comparison of the self-concepts between the two groups; and Ho_1 among the experimental groups, i.e. that the self-concept of the males would be higher than that of the females, were tested for the significant difference at the .05 level. Student's T test, which is a difference between the means test, was used for this. The second instrument, the personal interview schedule, was administered personally by the authors of the study to the experimental group only. (See copy of the guide for the personal interview in the appendix.) Since the experimental group is made up of males and females, significant differences on selected variables between these two types in terms of their sexual behavior patterns were tested by the use of Fisher's Exact Probability Method and chi square.

CHAPTER III

RESULTS OF DATA ANALYSES AND CONCLUSIONS

Results

In considering the results, we should keep in mind that the self-concept scores are negatively scored, i.e., the lower the score, the more favorable the self-concept. All tests were tested for significance at the .05 level.

The hypotheses as stated in Chapter II are, as follows:

H_1 The mean self-concept score of the experimental group will be significantly less favorable than the mean self-concept score of the control group.

H_2 The mean self-concept score of the males will be more favorable than females in the experimental group.

H_3 It is generally hypothesized that there will be differences between males and females within the experimental group with respect to certain characteristics of sexual behavior.

Table I
FAVORABLENESS OF SELF-CONCEPT
EXPERIMENTAL AND CONTROL GROUPS

Group		Mean	Standard Deviation
Experimental	(N = 34)	26.15	4.10
Control	(N = 34)	22.71	3.09
		$t = 1.24$	$t.05 = 1.67$

As can be seen from Table I, the difference between the means of 3.44 was found not to be significant at the .05 level. Although the self-concept of the control group was more favorable than that

of the experimental group, and in the direction suggested by the hypothesis, the difference was not sufficiently great to reject the null hypothesis of no difference.

Table II
FAVORABLENESS OF SELF-CONCEPT BY SEX
EXPERIMENTAL GROUP

Sex	Mean	Standard Deviation
Males (N = 20)	27.65	4.11
Females (N = 14)	24.00	2.98
	t = 2.81	t.05 = 1.67

Table II indicates that the mean difference of 3.65 was found to be statistically significant, even beyond the .01 level, but in the opposite direction as that stated in H_2; in other words, of the patients being treated for venereal disease, the females had a more favorable self-concept than did the males.

Certain comparisons were made on discrete forms of the data with respect to H_2. Three Fisher Exact Probability tests were made with regard to the relationship between self-concept and sex, self-concept and age of males, and self-concept and age of females.[23] The first test was made after dichotomizing self-concept frequencies into categories above and below the median of self-concept scores for males and females.

---

[23] Hays, William L., Statistics for Psychologists, New York: Rhinehart & Winston, 1964. pp. 598-601.

Table III
FAVORABLENESS OF SELF-CONCEPT BY SEX
EXPERIMENTAL GROUP

Sex	Self-Concept Above the Median	Self-Concept Below the Median	Total
Male	14	6	20
Female	3	11	14
Total	17	17	34
	P = .006	P<.01	

Table III indicates a significant difference. However, as the test did not result from a directional hypthesis, one can only infer, ex post facto, that the data is suggestive of a relationship between the male sex and favorableness of self-concept.

Tables IV and V present the Fisher Exact Method results for males and females within the experimental group respectively dichotomized according to the classifications of self-concept and age. Self-concept again was categorized as being either above or below the median self-concept score. The age categories for both males and females were on the basis of adults (age eighteen and over) versus minors (age seventeen and under), a legal classification used to test for empirical differences within this group.

Table IV
SELF-CONCEPT BY AGE,
MALES, EXPERIMENTAL GROUP

Age	Self-Concept Above the Median	Self-Concept Below the Median	Total
18 and over	9	5	14
Under 18	5	1	6
Total	14	6	20
	P = .38	P>.05	

Table V
SELF-CONCEPT BY AGE,
FEMALES, EXPERIMENTAL GROUP

Age	Self-Concept Above the Median	Self-Concept Below the median	Total
18 and over	1	4	5
Under 18	2	7	9
Total	3	11	14
	P = .49	P >.05	

Both Tables IV and V failed to reveal any significant association between degree of favorableness of self-concept and the adult-minor classifications of age.

Before considering the results of H_3, the results of comparisons on selected items (items which we were allowed to ask the control group) should now be mentioned. The most significant of the eight items on which comparisons were made was the item dealing with whom the subjects lived.

Table VI
PERSON(S) LIVED WITH BY TYPE OF GROUP

Group	Living with One Parent	Living with Both Parents	Total
Experimental	12	8	20
Control	6	26	32
Total	18	34	52
Chi Square = 13.1	Chi Square .01 = 6.6		P <.01

Table VI indicates a high statistically significant difference between the two groups. However, this difference is not accounted for in terms of a directional hypothesis, but, again, *ex post facto*, the data suggest a relationship between the control

group and living with both parents. When the two categories of living with either one or both parents were combined and all other categories were placed into the category "Other", Chi Square was still significant beyond the .01 level. This significance held true when the two groups were tested in contingence with the six response categories forming a 2 x 6 table. This result, however, would be expected since the control group was a younger sample.

The vast majority of both groups were single and Protestant. Concerning education, only two of the experimental group had completed twelve years of schooling, while twenty-eight had a tenth grade education or less. All of the control group were in school. Ten of the experimental and none of the control group planned to quit school at age sixteen. Nine of the experimental versus thirteen of the control did not plan to quit school. For those who planned to quit between the ages of seventeen and twenty-two, ten of the experimental versus eighteen of the control group so indicated.

As expected, none of the control group were working full-time, but only four of the experimental group were employed full-time. Three times as many of the control group (seven) were working part-time as compared with the experimental group (two).

Both the experimental and control groups reported that most of their friends were near their age, twenty-seven and thirty, respectively. Twelve each, for both groups, reported they had nine or more close friends. Twenty-one of the experimental versus

seventeen of the control group reported they had five or fewer close friends.

Hypothesis III stated that there would be differences between males and females within the experimental group with regard to certain characteristics of sexual behavior, sex and venereal disease information. The following results were found. Item 17 showed that more females than males get sex information from parents or other adults (yet there were more males than females in the sample). In addition, they were about equally divided on the category of learning about sex from their friends.

The mean age at first sexual intercourse for the males was 12.7 and a mode of fifteen; for the females, the mean was 13.5 and the mode fifteen. The mean age of their first sex partner for the males was 13.00 with a bi-modal distribution of twelve and fourteen. For the females, the mean was 16.00 and the mode fifteen.

With regard to where the act of coitus usually occurs, most of both males (sixteen) and females (eleven) reported that it was either in their own home, sex partner's home, or other home. There was only one respondent each for the category "in a car". Only two females and one male reported the use of either a motel or hotel.

Whereas all the females reported their sexual activity as having been with males only, four of the twenty males reported sexual activity with both sexes. Three each of both sexes indicated that money was involved.

In response to why they have sexual intercourse, fourteen of

the males and five of the females gave the answer "I enjoy it." Only one each reported that the reason was to keep a steady girl or boy. Neither sex reported engaging in sexual intercourse "to be popular."

For the males, eight out of twenty responses showed that sexual activities outside of marriage went against either their religious beliefs or their parents' beliefs. In this respect ten of the sixteen female responses were the same. Twelve male responses versus six female responses showed that sexual activities outside marriage neither went against their religious beliefs, their parents' or their friends' beliefs.

Of the number of sex partners they had had in the last month, the mean number for males was 3.95 and for the females was 1.3 with the modes being three and one respectively. The range for the males was twelve versus three for the females.

Whom they usually have sexual intercourse with, there was more diversity among males than females. The males reported that coitus took place with either their steady girl (seven) or a date (eight) versus eleven and none respectively for the females. Three males versus no females indicated the category "a pick up". One male and one female reported incestual relations with a sister or brother respectively.

Ten of the males and four of the females reported that they either "usually" or "sometimes" drink alcoholic beverages before having sexual intercourse. Conversely, ten of the males and ten of

the females stated that they either "hardly ever" or "never" drink alcoholic beverages prior to intercourse.

When asked if they enjoyed sexual intercourse, all of the males versus twelve of the females indicated that they either enjoyed it "always", "usually" or "sometimes". For both sexes the majority responded to the "sometime"category and only two females responded to the "hardly ever" category.

The following results pertain to venereal disease knowledge and attitudes.

When asked to identify the following--syphilis, "crabs", fever blisters, gonorrhea, diarrhea, and "clap"--and indicate which ones were venereal diseases, both sexes knew, as a rule, which ones were venereal diseases.

On the item pertaining to the way in which one can contract a venereal disease, one-half of all the responses for both males and females were correct. The categories receiving the next highest number of responses were "toilet seat" and "kissing".

The majority of both sexes indicated that either "some concern" or "great concern and fear" would probably best describe their friends' reactions when they learned they have been exposed to a venereal disease.

With regard to whom they should tell after they learn they have a venereal disease, the majority of both sexes indicated they should tell either their steady sex partner or any person with whom they had had sexual intercourse with recently. Only six responses

each, out of a total of twenty-nine and twenty-four, respectively, for males and females, indicated that one should tell his parents. There were only three male and no female responses indicating that one should tell his "best friend."

In response to the item "Why do you think you caught a venereal disease?" the males attribute it to "lack of protection" and "new sex partner" (nine responses each for a total of eighteen out of twenty-five) where females attribute it to "lack of protection" and "other reason" (six responses each for a total of twelve out of eighteen). There were only three male and no female responses for the drunk category.

The mean number of times the male had been treated for a venereal disease before was 2.6 times with a range of nine. For the females the mean was 1.9 and the range was four.

In response to "How did you hear of the clinic?", thirteen of the twenty-two male responses indicated the "friend" category, while there were only three out of seventeen female responses for this category. The second largest number of responses for the males and females was the "parents" category. Only one female response showed the "health officer" category as a source.

Eight males and nine females indicated that when one learns he or she has a venereal disease, he usually would first seek advice from "doctor or clinic". More males (six) than females (three) indicated "parents" as a first source of advice.

Most males (thirteen) and females (eleven) reported that they

would like to be able to talk to someone that they could trust freely about having venereal disease.

Thirteen of the males and five of the females indicated that one could catch a venereal disease from either sex. Five of the males thought one could catch it from females only, whereas four of the females indicated venereal disease could be caught from males only. Two males and five females indicated that they did not know.

There were only three male responses versus seven female responses out of twenty-three and nineteen respectively, indicating that once one has venereal disease he would usually try and conceal it from his "parents". There were only seven male versus five female responses indicating that most people would try to conceal it from "everyone". There were ten male versus five female responses, indicating most people would try to hide it from their "friends".

Fifteen of the males versus nine of the females (both a majority) thought one could catch venereal disease again once they had contracted it.

Five of the males and two of the females thought gonorrhea was caused by strain as in lifting a heavy object. Seven and six respectively responded negatively to this. While eight and six respectively said they did not know. For the "yes" and "don't know" categories combined, thirteen of the males and eight of the females indicate erroneous or lack of information.

As to whether or not one can look at a person and tell if he or she has a venereal disease, the majority of males (thirteen)

and females (ten) said no. Six of the males and three of the females did not know. Two males and one female thought one could tell by looking.

To the question of whether one can be born with syphilis, eight of the males and six of the females responded to the "yes" category. Twelve of the males and eight of the females said either "no" or "don't know".

Four of the males and no females thought a quick cure for venereal disease could be bought in a drug store. The "no" response was six males and seven females indicating that they did not know either way.

CONCLUSIONS

With regard to Hypothesis I, the authors concluded that while the mean difference between the self-concept scores of the experimental and control groups were in the direction stated in Hypothesis I, these differences were well within the range of chance.

Hypothesis II, which pertained to males and females in the experimental group, was not supported. However, a significant difference between the degree of a favorable self-concept for males versus that for females was found with the difference favorable to the females. Therefore, the conclusion was that the basis for Hypothesis II was not valid.

Hypothesis III was supported by the data obtained from questionnaire items 17 through 46. The extent to which this hypothesis was supported by the data from those items was indeterminate from a statistical point of view, since they were not subject to statistical analysis due to more than one response being allowed for several of the items. The implications from Hypothesis III have been discussed at length in Chapter IV.

Further, it was concluded that favorableness of self-concept was probably associated with sex, but not with age, males having a less favorable self-concept than females.

CHAPTER IV

RESULTS AND CONCLUSIONS OF PERSONAL INTERVIEWS

These interviews which consisted of open-ended questions were considered of major importance as they permitted a free response from the patient. The patient was allowed to answer on his own terms and within his own frame of reference. Most important, as social workers, we were able to gain some insight into his attitudes and feelings with regard to sex and his contracting venereal disease. Through the medium of the personal interview, the relationship established, and the rapport gained, we felt we could begin to understand this adolescent patient as a unique individual and establish how he felt about himself. Further, we were interested in the problem areas which might emerge from interviews--problems that we might have overlooked in the schedule. We needed to attempt to understand the impact of the interview situation itself and whether or not the patients could discuss these sensitive areas of their lives with openess and candor. We wondered to what extent we would encounter walls of resistance and resentment.

The primary aim of the personal interview, then, is to focus on the unique needs of the adolescent with venereal disease, to try to understand the confusion, troubles, and conflicts surrounding his attempts to cope with his sex drives in a culture that early emphasizes early gratifications of sensual and material needs.

This culture, at the same time, provides too few meaningful opportunities and makes too few socially useful demands of its youth. Out of the personal interview emerged certain salient results from which possible conclusions were inferred.

Results:

Of thirty-four patients attending the clinic only one parent accompanied her fourteen year old daughter.

In personal appearance generally, the patients were neat and clean. Using general standards of cleanliness and neatness, seventeen of twenty males and ten of fourteen females were observed to be neat and clean.

In attempting to determine how well this group related and responded verbally during the personal interview, we learned the following--fifteen of twenty males and ten of fourteen females seemed to relate well. Thirteen of twenty males and ten of fourteen females were very verbal.

As far as self-concept is concerned, according to the personal interviews, fifteen males and ten females manifested good self-concepts. When asked how they felt that others viewed or felt about them as individuals, fifteen males and ten females felt that they were well thought of by others.

Seventeen males and thirteen females voiced aspirations toward becoming gainfully employed, learning a trade or skill, completing high school and college, and making a career of the army.

Of this group of thirty-four respondents, four males and four

females attended secondary schools during the day and one male and one female attended night school.

Eight of fourteen females would marry someone who has or has had a venereal disease if he sought cure. Thirteen of twenty males would not marry a girl if they knew that she had ever had a venereal disease.

It was interesting to note the attitudes that our respondents held toward premarital relationships for their children. Twelve of twenty males objected to premarital relationships for their children and eight of fourteen females objected. Their major reason was fear of pregnancy. Only two based their objections on moral values.

Eleven males and six females received their sex knowledge from their peer group. One male and three females received sex information through the school. Only one male and two females received sex information from parents.

Those of the experimental group who expressed themselves regarding their leisure time activities indicated a preference for watching television. Males giving this response oftener than females. Males more frequently engaged in sports and females more often read. Both males and females liked movies. The males also enjoyed riding around "picking up girls".

Finally, premarital intercourse was generally accepted as a matter of fact.

Reactions of the respondents to the interview, were observed

as being relaxed, ashamed, embarrassed, apathetic, or tense.

Conclusions: Generally, the respondents appeared to be neat and clean and to have average intelligence.

1. Even though their reactions varied at the beginning of the interview, as rapport was established, they generally responded appropriately, related well, and were verbal.
2. Typical adolescent behavior is manifested by the experimental group in that they all adhered to the code of the group as it related to premarital relationships for themselves. Their being seen in the venereal disease clinic is indicative of their having engaged in premarital intercourse. Yet they voiced disapproval of premarital sex relationship for their children. Their reasons for objecting was fear of pregnancy for the girls and forced marriages for the boys. Moral values were scarcely mentioned.
3. The consensus was that contracting venereal disease was not catastrophic if one sought cure for it. They did not seem to fear venereal disease.
4. More sex information was received from their peer groups and school than from their parents.
5. The goals and aspirations of the respondents generally tended to be realistic and readily attainable. The males seemed to desire jobs in industry of a semi-

skilled nature. The majority of the females expressed desires for happy marriages, good homes, and good lives for their children. They also aspired to becoming clerical workers, waitresses or beauticians. Among those attending school, most respondents expressed desires for professional careers.

6. The leisure activities of the respondents do not seem to differ greatly from the leisure time activities generally associated with other adolescents in this age group. The activities most often mentioned are viewing television, reading, dating, movies, sports activities, joy riding, congregating with their friends, and going to parties.

Included in Appendix III are exerpts from seven personal interviews. These representative interviews revealed the subjects with their individual goals and interests, their attitudes toward sex and venereal disease, and their leisure time activities and problems. We were able to review with them their sexual experiences which culminated in their contraction of venereal disease. We also learned the source and reliability of their sex and venereal disease information.

The above mentioned information has been recorded in the body of the study. Not recorded are other points in our findings, which are unique. These are incest, an eighteen year old still in high school, a subject objecting to premarital coitus for her children on religious grounds, and a female with an apparently low self-concept who verbalized poorly.

CHAPTER V

SUMMARY, DISCUSSION, AND RECOMMENDATIONS FOR FURTHER STUDY

The first part of this study was undertaken to determine to what extent the subject had been previously studied and the areas where additional study was most indicated. To this end, a survey of the literature was undertaken. The report of these findings and a general introduction into the scope and many facets of venereal disease are outlined by the authors in Chapter I.

Chapter II, entitled "Methodology", outlines the scope, limitations, and statistical procedures of the study. This includes how both samples were selected and why, how the questionnaires were administered to both the experimental and the control groups, the outline of the personal interview, a discussion of the two questionnaires, and an outline of the statistical procedures employed.

Chapter III presents the results of the collected data with concluding remarks.

In Chapter IV the results of the personal interviews are presented along with concluding remarks.

What follows is a discussion of the inferences drawn from the analysis of the data and the personal interviews with recommendations for further study.

In our original proposal we stated three hypotheses, one of which was that the mean self-concept score of the experimental

group would be significantly different from the mean self-concept score of the control group. Although the self-concept of the control group tended to be better than that of the experimental group, the difference was not statistically significant. However, the inferences made from item 5, which asked with whom the respondents were living, and Table I which illustrates the difference in the favorableness of self-concept between the two groups seemed to indicate that there is less stability in the experimental group than in the control group. This instability presents the experimental group with greater opportunity for sexual promiscuity and, hence, for the contraction of venereal disease. Amore stable enviornment lessens the opportunity for the control group.

Items 8 and 9, concerning the highest grade in school completed and the age at which the respondent planned to quit school, seem to support the inference drawn from item 5 (less stability in the home) that the control group appears to be more achievement-oriented because they plan to remain in school longer. In addition, one may infer or accept this orientation as being evidence to support the more favorable self-concept held by the control group.

The results of item 10 show that most of the experimental group are not in school and are not working. This is compatible with the above indication that there is more time available for indulgence in sexual promiscuity through which venereal disease is contracted.

The results of items 13, 14, and 15 concerning the age, sex,

and number of the respondents' close friends shows no difference between the age groups.

In the use of leisure time, the control group was twice as active as the experimental group. However, when the authors compared information taken from the personal interviews with the experimental group with the information taken from the questionnaire completed by the control group, they found that the leisure time activities of the respondents do not seem to differ greatly from the leisure time activities generally associated with other adolescents within this age group. Activities most often mentioned are veiwing television, reading, dating, movies, sports activities, joy riding, congregating with their friends, dancing, going to parties, and listening to records.

As was explained in the chapter on methodology, the authors were not permitted to question the control group on sex or venereal disease. Therefore, our discussion from this point will be confined to the experimental group only--to their sex knowledge, sexual behavior patterns, and knowledge of venereal disease. Also included are the respondents' attitudes regarding these subjects as found in personal interviews.

Item 17 identifies the source of the respondent's sexual knowledge. Most sex information and misinformation was learned outside the home from friends and peers. This seems to hold true more with males than females. In the authors' opinion, sex misinformation does not prepare the adolescent psychologically to

engage in premarital sex. Misinformation also seems to be conducive to depersonalized sexual intercourse which was defined in Chapter I as sexual promiscuity.

Items 18 and 19 question the age at which first sexual intercourse was experienced. The mean age at first coitus for the females is higher than that for the males. The mean age of the first sex partner is much higher for the females. One could infer that middle adolescent males are introducing early adolescent females to sexual intercourse, who in turn are introducing early adolescent males to coitus.

Item 20, which questioned where respondents engaged in intercourse, indicates that, contrary to popular belief, the respondents usually have sexual intercourse in a home rather than in a car or motel. This statement is corroborated by the Kinsey report which noted that one-half to three-quarters of all the coitus had by the female in the sample seemed to have occurred in the home of the female or male.[24] In this report, the automobile seemed to have no more significance in providing a place for coitus than the buggy in earlier days.[25]

Items 21, 22, 23, 25, 26, and 29 relate to the respondents'

---

[24]Kinsey, Alfred C., et al, Sexual Behavior in the Human Female. Philadelphia: W. B. Saunders Co., 1953, p. 311.

[25]Ibid., p. 310.

sexual behavior patterns. Only three respondents mentioned homosexual relations.

There was no money involved in the sexual relationships of this group which indicates no prostitution. They also responded that they had sexual intercourse because they enjoyed it, which supports the item of not accepting money. "There is no doubt that coitus, both before and after marriage, is had primarily because it may satisfy a physiologic need and may serve as a source of pleasure for one or both of the individuals who are involved. No appreciable part of coitus, either in or out of marriage, is consciously undertaken as a means of effecting reproduction."[26] Contrary to popular belief, the female is not having sexual relations to keep her "steady", as indicated by item 23.

There are more males engaging in sex with more partners than there are females. The authors infer from this comparison that the male is the primary transferer of venereal disease, while the females tend to be engaged in coitus with one person--their "steadies". Kinsey found that among females, 53% had had coitus with only a single partner prior to marriage.[27]

As indicated by item 24, the females especially seem to adhere to middle-class values in that they say that sexual intercourse outside of marriage goes against their beliefs or their parents' be-

---

[26] *Ibid.*, p. 16.

[27] *Ibid.*, p. 292.

liefs. The males response that there is apparently no reason why they should not engage in pre-marital sexual intercourse. It would seem that, since the males see no reason not to engage in pre-marital coitus, they are adhering to the values of the sub-culture.

Personal interviews support the foregoing implications in that the males did not want their children to engage in pre-marital cohabitation. The objections were on the basis of pregnancies and forced marriages. They seemed to have no objections on moral grounds. The females also objected to pre-marital coitus for their children for the same reasons as the males; however, two of the females objected on religious or moral grounds.

The responses to item 27 indicate that the drinking of alcohol is not a characteristic associated with adolescents and sexual relations.

Items 30 and 31 show that about half of the respondents knew by name the venereal diseases. These items further indicated that neither males nor females knew the correct source of venereal disease. However, item 39 indicates that males are a little more knowledgeable about the source of venereal disease than the females.

Males attribute their contraction of venereal disease to lack of protection and a new sex partner, according to the responses of item 34. The females attribute their contraction of venereal disease to a lack of protection and "other reasons". This is indicative of the fact that the respondents have a certain degree of knowledge about how they contracted venereal disease.

The responses to items 41 through 45 indicate that there is a general lack of knowledge and considerable confusion on the part of this group concerning venereal disease as a whole.

As revealed in the personal interviews, the respondents' attitudes and reactions toward venereal disease varied at the beginning of the interview from being ashamed and embarrassed, to being tense or apathetic. As rapport was established, they generally responded appropriately, related well and were very verbal. Most believed that venereal disease could be easily cured. Some males feared impregnating their "steadies" and always used contraceptives. Strange as it may seem, they never feared impregnating the "pick ups". This did not deter their sexual activities with the "pick ups" without the use of contraceptives. It did not seem to occur to them that the use of a contraceptive may have protected them from contracting venereal disease. As might be assumed from this discussion, most of the sexual experiences of the males seemed to be casual affairs.

The females seemed to have no guilt as they tended to adhere to the code of the teenage sub-culture. They only had coitus with their "steadies", which is, to them, acceptable behavior. They were, therefore, less promiscuous. The males rarely expressed guilt. They seemed to believe that they were engaging in behavior which is considered normal for boys. Their attitudes toward girls other than "steadies" seemed to be one of convenience for themselves and was rarely one of respect. Many males said that a girl should know that she had venereal disease and they seemed quite resentful

about this.

The consensus was that contracting venereal disease was not catastrophic if one sought a cure for it. The authors feel this may be a healthier attitude than one that would inhibit seeking proper medical treatment.

Contrary to other studies read in our survey of literature, these respondents appeared to have goals and aspirations which seemed realistic and readily attainable.

We hypothesized that the self-concept would be more favorable among males than females in the experimental group. A statistically significant difference was found in the opposite direction of the above hypothesis which indicates that females have a more favorable self-concept. Yet as our hypotheses was not so constructed to account for this reversal of direction, this cannot be accepted as definite. In an attempt to determine the reason for this reversal of direction in our hypotheses, we compared the school achievements, the occupations or lack of occupations and the composition of the homes. In each instance, the male showed a more favorable circumstance which we thought would be conductive to a more favorable self-concept. The only instance that we found in which the female seemed to be in a better situation was that they seemed to feel more secure in their sexual relations with their "steady". The male who more often engaged in sexual relations with casual acquaintances, breached the code of the teenage sub-culture. Contrary to the statistical findings, the personal interviews revealed that most of the males

had more favorable self-concepts than the females.

The authors feel that (although the basic unit of our society is the family) it is significant that only one patient in the entire study of thirty-four adolescents was accompanied by her parent. The apparent lack of concern and involvement of parents with their adolescents in their failure to supply their children with adequate sex and venereal disease information is painfully noticeable. Home is the psychological laboratory within which human nature is formed and parents are the socializing agents. A major contribution to be made by social work is to initiate more family-life education programs in an effort to reach parents. They could be furnished with wholesome and proper sex and venereal disease information which might stimulate them to defend and teach, with respect, what is socially desirable and acceptable--i.e., the sensitive subjects of sexual intercourse and other aspects of boy-girl relationships in a compassionate, yet non-judgmental manner.

Of worthy note and special significance was the consistent positive response to item 38, which asked "Would you like to be able to talk freely to someone you could trust about this problem?" The responses indicated to the authors the urgent need for social casework services in this type of setting.

Recommendations for Further Research

From this study it seems evident that sexual promiscuity is a problem of considerable magnitude - one involving many of our youth and which may, in low socio-economic neighborhoods and among particular groups, include the majority of young boys and girls. One problem that results from sexual promiscuity is the contraction and spread of a venereal disease. As in the instance of many diseases, a first step in prevention or treatment is knowledge of the incidence of any given phenomenon. It is of pervasive importance, then, that the extent and characteristics of sexual promiscuity and venereal disease be accurately described. Our present knowledge, at any level, is so inadequate that efforts to formulate programs of prevention or treatment are necessarily premature.

Because social work is a helping profession, where help is given usually on a one-to-one basis, it is not recommended that sociological research be undertaken, i.e., the delineation of rates and incidence of certain phenomena. More germaine to the field of social work, and a problem area uncovered in this study, is research into establishing the need for social work for adolescents who find themselves in problem situations as a result of sexual promiscuity. The following questions appear to bear heavily in this regard: Would proper sex and venereal disease information serve as a deterrent to sexual promiscuity and, hence, the subsequent contraction of venereal disease? If so, how and who should administer

the diffusion of this information.

An unfavorable self-concept was not, in this study, found to be associated with whether or not the subjects had a venereal disease. Is self-concept crystalized at such an early age that sexual promiscuity reflects a sub-cultural more within certain segments of our society? The answers to these and many other questions become of great utility to the social worker by increasing his store of knowledge. A social diagnosis is an assessment of a person's present life situation. We know how our client contracted a venereal disease, but the question is, do we understand the dynamics associated with sexual promiscuity enough to help our client help himself?

APPENDIX I

SAMPLE INTERVIEW NO. 1
Negro - Female - Age 17

Low Range
Self-Concept

This respondent was a rather plain, neat girl, who has spent time at institutions for delinquent boys and girls. She was cooperative in the interview situation, but obviously was so used to talking to social workers that she answered questions before they were asked, and made cynical comments throughout. She seemed without much affect, although verbally she expressed a few strong feelings (against being followed closely by probation officers).

She described herself to me as "eighteen years old, 5' 4", weight--135 pounds, and was a 'Nigero'". She first said she wanted to be a beautician since she received training for this for a year, and received a diploma. She thinks of herself as "a sweet girl when she wants to be". She is now living with her sister, preferring this situation because her sister doesn't tell her what to do. She contradicted her earlier statements later by saying she probably could start to work as a beautician next week, but was "really kind of sick of fixing peoples' hair all the time." She also volunteered she might like to be a nurse, and wants to look into the possibility of attending Ahrens Trade School. She spends most of her time at present taking care of her sister's children, playing cards, and visiting with people in the "Project" where they live.

When asked how another person might describe her to me she said "oh probably, she's no good, might be pregnant, and if she is wouldn't even know who the father was."

In general her demeanor was sort of a poignant cynicism with lack of trust in anyone.

She has sexual relations only with one person - a steady she has had intercourse regularly since she was about twelve or thirteen. She learned about both sex and venereal disease via the grapevine. She came to the Clinic because her boy friend suggested it (she thinks he caught it from her sister). She told me she would object to her children having sex relations before marriage, because "she's been through it and knows it doesn't work out."

SAMPLE INTERVIEW NO. 2 Low Range
Negro - Male - Age 17 Self-Concept

This a relaxed appearing young Negro male, age 17, who was wearing a silk ascot and had chewing gum stuck to the back of his right.hand. He wore inexpensive but clean looking clothe . He verbalized easily and responded appropriately to all questions.

He does not work regularly or attend school; he states that he wants to attend Ahrens Trade School and become an auto mechanic. He thinks of himself as a pretty good guy and believes that others consider him a nice, mannerly and responsible person.

He would not have any disrespect for others who have venereal disease as long as they sought a cure, otherwise he would not respect them. His free time is spent playing pool, ball, riding in and fooling around with cars, and a little work during the daytime. Evenings he watches television or visits girlfriend's house where they play records. He does not run around much with boys in the evening.

The respondent engages in intercourse both day and night, weekdays and weekends with one girl and always at her house; yet his stated frequency of intercourse is once per week. He would object to his children engaging in pre-marital intercourse until they were at least eighteen because they "could get into trouble if they did, especially girls." After age eighteen, "they're going to do it anyway and there is no way to stop them." He felt intercourse was the natural thing for people to do regardless of marriage.

He does not feel bad or ashamed of having venereal disease and does not think he will get it again because he has a "good plan," i.e., get protection from the drug store man. Subject learned about venereal disease and sex from peers and adults at age thirteen. He believes venereal disease can "mess one up," i.e., lose use of one's penis. Also he believes that having venereal disease will affect one's children. He would marry someone who has had venereal disease but not someone who currently has it.

SAMPLE INTERVIEW NO. 3
Negro - Female - Age 17

Middle Range
Self-Concept

The respondent was a small, neat, rather attractive seventeen year old female negro, who appeared to be quiet and was a little hesitant or shy. She is the youngest of four children. She is nine years younger than the next oldest child. Her mother died when she was three years of age. The older sisters did the housekeeping for the father who had regular employment in a factory. The sisters married and moved out of home when respondent was seven years of age. The father did the house work and continued in his employment.

When respondent was twelve years old, Juvenile Court authorities came to school and got her. This was her first knowledge that she was being removed from her home. She learned that her father was being accused of operating a house of prostitution in their home by allowing couples to come there. She denies that there was any truth to these charges. She also denies that her father had ever abused her. She was very upset about being removed from her home.

She was placed in an institution and later in a foster home. The placement was not successful so she was taken back to the institution. She ran away and started walking to her sister's home which was located in a housing project. On the way, she noticed a boy walking on the opposite side of the street. He finally joined her and they continued to walk toward the sister's home. Upon reaching the apartment, she saw a light was on but the apartment next door was dark. She knew her sister would send her back to the institution; so she told the boy that her sister was not at home and that she did not know where she would go. He took her to his apartment which was

shared by his brother. The boy was nineteen and the brother older. She stayed there two nights and had intercourse with both boys. This was her first experience with sexual relations.

She voluntarily returned to the center. She was again placed in a foster home with an elderly woman who had three girls she was boarding. The woman wanted the girls to prostitute with men who came to the house. She received $5.00 and $10.00

The respondent said she did not like prostitution and left the home. She worked in homes for her keep. In these homes she was allowed to date. She engaged in sexual intercourse quite frequently with various men, she could not remember how many.

She was soon returned to the institution. Later at the age of fourteen she went to stay with her sister where she cared for the sister's children while she was away. Her brother-in-law had a friend who started coming to the home and visiting her. She became pregnant by him. She stayed with her sister until after the baby was born. Later she had another child by a different father.

Both these children are in foster homes. She does not want to release them for adoption but cannot afford to keep them. She receives social security benefits on her own father's earning. The respondent lived in common-law relation with one man for a few months. He was abusive and mistreated her and was having sexual relations with other women at the time. She went to a state mental hospital as a patient but was told there was nothing wrong with her. She started working at the hospital where she had met a married man age twenty-three who also was employed there. She began having sexual relations with him

while she was still living in common-law with the other man. She contracted "clap" twice from her common-law spouse and she in turn gave it to the man working at the hospital. When her common-law husband was sent to prison, she rented a place and now lives alone.

Her boy friend comes to see her almost every evening and they have sexual relations almost every time. He continues to live with his wife but does not have sex relations with her.

The respondent says she is sure that neither she nor her boy friend has had sexual intercourse with anyone else. She cannot understand how she got infected this time, unless it is a re-occurance of the previous infection. She has no ill feeling towa d boy friend. She would like very much to marry him, if he were free to marry.

She is not too concerned about having venereal disease. She believes that her children will engage in premarital relations. She plans to tell her daughters about sex and about protection.

The respondent keeps insisting that she has no friends.

SAMPLE INTERVIEW NO. 4
White - Male - Age 16

Middle Range
Self-Concept

Respondent was observed to be hesitant and ill at ease. He stood about six feet tall and was slightly stooped. His appearance would be described as not neat. The denim jacket and trousers he wore were not clean and his hair was untrimmed. This person was willing to talk and seemed to be of low average intelligence. He seemed to be honest and frank in his responses.

Respondent describes himself as being an average person. He states he is pretty well liked and has several friends his own age. He has one boyfriend he runs around with. He has been in trouble once with the law. At the suggestion of another boy, he and two others broke into a store. He spent eight days at Children's Center and was released when the merchant dropped the charges. When he becomes seventeen years of age, he would like to enter the Army and learn the mechanics trade and marry his steady girlfriend. He states he is "pretty good tinkering with motors", and has repaired auto motors. He has worked some for "Mr. Softee" ice cream truck.

The respondent was brought to the clinic by a juvenile court worker. Charges of incest have been placed against father and older brother. He and three sisters are now at Reception Center as dependent children. The mother is hospitalized for "nervous breakdown". He was placed in a foster home at the age of nine. He was returned to his home four years later.

His first sexual experience was with a neighbor girl while staying at the foster home. He was thirteen years old - the girl

was twelve. The same year, after returning to his home, he had sexual intercourse with a girl at her home in a housing project. She was also about his age. One one such experience with each of these girls took place.

About a year ago he began having sexual relations with his thirteen year old sister in their home. This has occured about five times. He has had intercourse with a fourteen year old sister one time. Once or twice during the interview respondent stated he wished his family had not gotten into this mess. He stated his younger sister did not seem to mind having relations, but would always tell parents.

Patient has a steady girlfriend sixteen years of age. He states he went with her about eight months before he could persuade her to have sexual relations. This has occurred about eight times, usually at drive-in movies. The girlfriend had had only one previous sex experience when she was forced by her cousin at a drive-in. This occurred two or three months before he started going with her.

The respondent believes he would object to his son's having pre marital sexual relations as the girl might become pregnant. He would not want daughter to have pre marital sex relations as people would talk about her.

The respondent does not seem to have any knowledge of venereal disease. He had heard boys at school talk about "crabs" and thought they were bugs. He was not familiar with terms in Question #30.

He does not use protection and is a little bit concerned about getting his girlfriend pregnant but she has told him they will get married if she does.

SAMPLE INTERVIEW NO. 5
Negro - Female - Age 18

Middle Range
Self-Concept

This was a very attractive, alert, relaxed, rather blasé person. At times she seemed coquettish and was certainly a sophisticated girl.

The respondent described herself in the following way: She lives alone with her two children, is separated from her husband, and is now working as a carhop. The two children are four months and seventeen months; she married her husband only six months ago at his insistence. The patient did not finish high school, having dropped out because of her first pregnancy. She expressed a desire to do clerical work eventually. Her husband (by whom she was infected) is described as "always being in and out of jail," and refuses to work. She is supported financially by her mother and by her boyfriend. She came to the Clinic at the urging of her boyfriend, when he began having symptoms.

The patient was very definite about not marrying again, and told me she does not plan to get pregnant; she has been taking "the pills" for the last several months. In response to questions about how she felt about coming to the Clinic, she volunteered "I think it is terrible for anyone to have venereal disease". She told me she certainly hates being a patient herself. Her attitude toward sex relations was one of almost apathy. Before she got pregnant, she was having intercourse with her husband several times a week. This took place when they both skipped school and went to his home. She said

that eventually her husband wanted sex all day long everyday. The frequency with current boyfriend is about twice a week. As far as what she would tell her own children about sex and venereal disease, she said she didn't see any point in trying to keep them from having sex relations before marriage, because they are going "to do it anyway." She told me she hopes her own children wouldn't have any children.

SAMPLE INTERVIEW NO. 6 — High Range Self-Concept

Negro - Male - Age 18

Respondent was cocky, sharply dressed with rings and fancy wrist watch. He was wearing a mustache, was bored with the interview and in an extreme hurry to get to an appointment to see about a job. He did not wish to wait the twenty minutes required after treatment, but complied only at the worker's continued insistence.

He plans to be "prosperous doing whatever I do," "I'm a regular person," "No I'm not going to marry anybody"; "Some classes like me, some don't"; "I have very few enemies; it depends on how I carry myself"; were some of his comments. He related he may become a journeyman electrician.

He feels a girl can't do what a boy can do, as she has "to keep her respect;" "a boy can get by with a lot more" (regarding sex). He doesn't know if he would marry a girl who had had venereal disease. In regard to the number of his sex partners, he remarked, "I don't know I try to satisfy everybody."

APPENDIX II

FORM________________

Number______________

SCHEDULE A

Age_________________

Date Interviewed_________

Interviewer____________

CONFIDENTIAL QUESTIONNAIRE for

Specialty Clinic

1. Please read carefully and complete all questions
2. Return completed form to Clinic Staff
3. It is not necessary to write your name.

FORM A Under 19

PART I

Please answer all of the following questions (in most cases by a check mark).

1. ( ) Male
   ( ) Female

2. ( ) Negro
   ( ) White
   ( ) Other ______________________
   (Write out your answer)

3. How old are you? ________

   What month and year were you born in? ____ month ____ year

4. Are you: (Check only one)

   ( ) Single
   ( ) Married
   ( ) Divorced
   ( ) Widowed
   ( ) Separated

5. Are you now living with:

   ( ) Both Parents
   ( ) One Parent
   ( ) Relative
   ( ) Husband or Wife
   ( ) Alone
   ( ) Other ______________________
   (Write out your answer)

6. Why did you come to the clinic?

   ( ) Of your own free will
   ( ) Sex Partner's request
   ( ) Friend's advice
   ( ) Health Department
   ( ) Juvenile Court
   ( ) Parents brought you
   ( ) Other ______________________
   (Write out your answer)

7. What religion do you believe in? (Check one only)

   ( ) Protestant
   ( ) Catholic
   ( ) Jewish
   ( ) Baptist
   ( ) No preference
   ( ) Other ______________________
   (Write out your answer)

THE WAY IT LOOKS TO ME

Circle "Y" if your answer is Yes; circle "N" if your answer is No; and circle "DK" if your answer is Don't Know. For questions 28, 29, and 30, circle "O" for Often, "N" for Never, and "S" for Sometimes. For questions 31 and 32, put an "X" in the right space. There are no right or wrong answers. The right answer for you is the way you look at things.

YES	NO	DON'T KNOW		
Y	N	DK	1.	Do you think that things are pretty well stacked against you?
Y	N	DK	2.	Will you probably be taken to juvenile court sometime?
Y	N	DK	3.	Did anyone ever tell you that you have a problem?
Y	N	DK	4.	Will you probably have to go to jail sometime?
Y	N	DK	5.	If you could start all over again, would you choose the same friends?
Y	N	DK	6.	If you found that a friend was leading you into trouble, would you continue to run around with him or her?
Y	N	DK	7.	Do you consider yourself to be a wise guy?
Y	N	DK	8.	Do you plan to finish high school?
Y	N	DK	9.	Do your parents punish you when you don't deserve it?
Y	N	DK	10.	Do you think you'll stay out of trouble in the future?
Y	N	DK	11.	Have you made up your mind that you won't get much out of school from now on?
Y	N	DK	12.	Are grown-ups usually against you?
Y	N	DK	13.	Do you expect people to give you an even break?
Y	N	DK	14.	If you could get permission to work at 14, would you quit school?
Y	N	DK	15.	Are you the kind of person that usually gets pushed around?

Y N DK 16. Are you a big shot with your pals?

Y N DK 17. Do your parents like it when you bring friends home?

Y N DK 18. Do you think your teacher thinks you will ever get into trouble with the law?

Y N DK 19. Are parents to blame if their children get into trouble?

Y N DK 20. Do you think that your mother thinks you will ever get into trouble with the law?

Y N DK 21. If you could start all over again, would you do the same things?

Y N DK 22. Do you think if you were to get into trouble with the law, it would be bad for you in the future?

Y N DK 23. Is it hard for you to have fun when you obey the law and your parents?

Y N DK 24. Have you ever been told that you were headed for trouble with the law?

Y N DK 25. Do you think your friends are good?

Y N DK 26. Have most of your friends been in trouble with the law?

Y N DK 27. Would you rather live somewhere else than at your home?

O S N 28. Do you confide in your father? (Circle "O" for often; "N" for Never; "S" for sometimes).

O S N 29. Do you think there is much fighting at home? (Circle "O" for Often; "N" for Never; "S" for Sometimes).

O S N 30. Do your parents punish you? (Circle "O" for Often; "N" for Never; "S" for Sometimes).

31. If you were real honest about yourself, would you say that you feel you are better than most_____as good as most______worse than most_______? (Put an "X" in the right space.)

32. Do you think you are quiet_____, average______, active______? (Put an "X" in the right space.)

PART II

8. What is the highest grade in school you finished?____________________

9. You quit school, or plan to quit at what age?____________________

10. Are you working? (Check only one.)

( ) Full-time
( ) Part-time
( ) Not working

11. If working, what kind of work do you do?____________________
(Write out your answer)

____

12. Where do you <u>usually</u> eat supper?

( ) At home with family
( ) At home alone
( ) Out with friends
( ) Out alone

13. How many close friends do you have? (Check only one answer.)

( ) 1
( ) 2
( ) 3
( ) 4
( ) 5
( ) 6
( ) 7
( ) 8
( ) 9 or more
( ) none

14. Most of your friends are: (Check only one answer)

( ) Male
( ) Female
( ) about equally divided

15. Are most of your friends: (Check only one answer)

( ) younger than you
( ) older than you
( ) near your age

16. What do you usually do in your spare time? (Put a check mark in all spaces which apply.)

	WEEKDAYS		WEEKENDS	
ACTIVITY	AFTERNOON	EVENING	SATURDAY	SUNDAY
WORK				
MOVIES				
GO OUT WITH STEADY				
ACTIVITY CLUB				
BASKETBALL				
SHOOT POOL OR BOWL				
GO DRIVING				
DANCING				
GO TO TAVERN OR BAR				
PLAY CARDS				
GO OUT WITH PICKUP				
WATCH TV				
HOMEWORK				
READ				
CHURCH				
GO OUT WITH DATE				
MEET WITH GANG				
GO TO DRUGSTORE				
DO WORK AROUND THE HOUSE				

PART III

17. Did you learn about sex from: (Check all that apply)

( ) Your parents
( ) Other adults
( ) School
( ) Friends
( ) Books or magazines
( ) Other____
(Write out your answer)

18. How old were you when you first had sexual intercourse?______________

19. How old was your partner?____________ ____________

20. Where do you usually have sexual intercourse? (Check one only)

( ) In a car
( ) In your home
( ) In partner's home
( ) At other homes
( ) In hotels or motels
( ) Outdoors
( ) Some other place__________________________________
(Write out your answer)

21. Has your sexual activity been with: (Check one answer only)

( ) Males only
( ) Females only
( ) Both

22. Was there any money involved? (Answer one only)

( ) Yes (usually)
( ) No
( ) Sometimes

23. Why do you have sexual intercourse? (Check all answers which apply)

( ) Everybody else is doing it
( ) For money
( ) To be liked
( ) To keep my steady
( ) I enjoy it
( ) To be popular
( ) Don't know
( ) Other reason__________________________________
(Write out your answer)

24. Do sexual activities outside marriage go against:

( ) Your religious beliefs
( ) Your parents' beliefs
( ) Friends' beliefs
( ) None of these
( ) Other________________________
(Write out your answer)

25. How many different sex partners have you had in the last month? (Check only one answer)

( ) 1
( ) 2
( ) 3
( ) 4
( ) 5
( ) 6
( ) 7
( ) 8
( ) 9
( ) 10
( ) 11
( ) 12
( ) 13
( ) 14
( ) 15 or more

26. Do you usually have sexual intercourse with:

( ) Steady
( ) Date
( ) Wife or husband
( ) Pick up
( ) Other________________________
(Write in your answer)

27. Do you drink alcoholic beverages before having sexual intercourse?

( ) Usually
( ) Sometimes
( ) Hardly ever
( ) Never

28. How many times do you have sexual intercourse in a month?____________
(Write in your answer)

29. Do you enjoy sexual intercourse? (Check one answer only)

( ) Always
( ) Usually
( ) Sometimes
( ) Hardly ever
( ) Never

PART IV

30. Which of the following are venereal diseases? (Check all answers which apply)

( ) Syphilis
( ) Crabs
( ) Fever blisters
( ) Gonorrhea
( ) Diarrhea
( ) Clap

31. You can catch venereal diseases from: (Check all answers that apply.)

( ) Toilet seat
( ) Doorknob
( ) Kissing
( ) Petting
( ) Shaking hands
( ) Sexual intercourse

32. Which would best describe your friends' reaction when they learn they have been exposed to venereal disease?
(Check one answer only)

( ) Great concern or fear
( ) Some concern
( ) Wouldn't think much about it

33. After a person definitely finds out he has venereal disease it is his duty to tell: (Check all answers which apply.)

( ) steady sex person
( ) best friend
( ) parents
( ) any person he or she has had sexual intercourse with recently
( ) no one
( ) other person_______________________________________
(Write in your answer)

34. Why do you think you caught venereal disease? (Check all answers that apply.)

( ) Lack of protection
( ) Unlucky
( ) New sex partner
( ) Drunk
( ) Other reason______________________________
(Write in your answer)

35. How many times have you been treated for venereal disease before?

____
(Write in your answer)

36. How did you hear of this Clinic? (Check all answers that apply.)

( ) Health officer
( ) Friends
( ) Parents
( ) Sex partner
( ) Juvenile court
( ) Other______________________________
(Write in your answer)

37. When a person thinks he might have venereal disease he usually would seek advice first from: (Check one only)

( ) Parents
( ) Close friend
( ) Sex partner
( ) Preacher
( ) Druggist
( ) Doctor or Clinic
( ) Other______________________________
(Write in your answer)

38. Would you like to be able to talk freely to someone you could trust about this problem:

( ) Yes
( ) No
( ) Don't Know

39. It would be possible for you to catch venereal disease from: (Check only one answer.)

( ) Males only
( ) Females only
( ) Either
( ) Don't know

40. Most persons, in your opinion, exposed to venereal disease try to hide it from: (Check all answers that apply.)

( ) Parents
( ) Friends
( ) Sex partner
( ) No one
( ) Everyone
( ) Other______________________________
(Write in your answer)

41. Can you get a venereal disease again once you've had it?

( ) Yes
( ) No
( ) Don't know

42. Gonorrhea or "clap" is caused by strain as in lifting a heavy object.

( ) Yes
( ) No
( ) Don't know

43. You can tell by looking at a person if he or she has a venereal disease.

( ) Yes
( ) No
( ) Don't know

44. Can you be born with syphilis?

( ) Yes
( ) No
( ) Don't know

45. A quick cure for venereal diseases can be bought in a drug store.

( ) Yes
( ) No
( ) Don't know

SCHEDULE B

The information requested in this questionnaire is extremely important to educators who want to develop worthwhile programs for teen-agers. The information contained herein will be held strictly confidential and you do not have to sign your name. Please read all questions carefully and answer all of them to the best of your ability. Turn the questionnaire in to the teacher in charge after you have finished.

1. Are you a boy _____ or girl _____?

2. Are you white ______ negro ______ or other? ______

3. When were you born? Month _________ Year _____

4. What is your street address? _______ ____________________
Number   Name of street

5. Are you: (Check only one)
( ) Single   ( ) Divorced
( ) Married   ( ) Separated

6. Are you now living with:
( ) Both Parents   ( ) Relative   ( ) Alone
( ) One Parent   ( ) Husband or wife   ( ) Other_______
write answer

7. What religion are you? (Check one only)
( ) Protestant   ( ) Jewish   ( ) No preference
( ) Catholic   ( ) Baptist   ( ) Other______________
write your answer

8. What grade are you in? ______________

9. At what age do you plan to quit school? ______________

10. Are you working? (Check only one)
( ) Full-time
( ) Part-time
( ) Not working

11. If working, what kind of work do you do? ____________________________

____
(Write out your answer)

12. Where do you usually eat supper?
( ) At home with family   ( ) Out with friends
( ) At home alone   ( ) Out alone

13. How many close friends do you have? (Check only one)
( ) 1   ( ) 6
( ) 2   ( ) 7
( ) 3   ( ) 8

14. Most of your friends are: (Check only one)
( ) Boys
( ) Girls
( ) About equally divided

15. Are most of your friends: (Check only one)
( ) Younger than you
( ) Older than you
( ) Near your age

16. What do you usually do in your spare time? (Put a check mark in all spaces which apply)

	WEEKDAYS		WEEKENDS	
Activity	AFTERNOON	EVENING	SATURDAY	SUNDAY
WORK				
GO TO MOVIES				
GO OUT WITH MY STEADY				
GO TO ACTIVITY CLUB				
PLAY BASKETBALL				
SHOOT POOL OR BOWL				
GO DRIVING				
GO DANCING				
PLAY CARDS				
WATCH TELEVISION				
DO HOMEWORK				
READ				
GO TO CHURCH				
GO OUT WITH A DATE				
MEET WITH FRIENDS				
GO TO DRUGSTORE				
WORK AROUND THE HOUSE				

THE WAY IT LOOKS TO ME

Circle "Y" if your answer is Yes; circle "N" if your answer is No; and circle "DK" if your answer is Don't Know. For questions 28, 29, and 30, circle "O" for Often, "N" for Never, and "S" for Sometimes. For questions 31 and 32, put an "X" in the right space. There are no right or wrong answers. The right answer for you is the way you look at things.

YES	NO	DON'T KNOW		
Y	N	DK	1.	Do you think that things are pretty well stacked against you?
Y	N	DK	2.	Will you probably be taken to juvenile court sometime?
Y	N	DK	3.	Did anyone ever tell you that you have a problem?
Y	N	DK	4.	Will you probably have to go to jail sometime?
Y	N	DK	5.	If you could start all over again, would you choose the same friends?
Y	N	DK	6.	If you found that a friend was leading you into trouble, would you continue to run around with him or her?
Y	N	DK	7.	Do you consider yourself to be a wise guy?
Y	N	DK	8.	Do you plan to finish high school?
Y	N	DK	9.	Do your parents punish you when you don't deserve it?
Y	N	DK	10.	Do you think you'll stay out of trouble in the future?
Y	N	DK	11.	Have you made up your mind that you won't get much out of school from now on?
Y	N	DK	12.	Are grown-ups usually against you?
Y	N	DK	13.	Do you expect people to give you an even break?
Y	N	DK	14.	If you could get permission to work at 14, would you quit school?
Y	N	DK	15.	Are you the kind of person that usually gets pushed around?

Y N DK 16. Are you a big shot with your pals?

Y N DK 17. Do your parents like it when you bring friends home?

Y N DK 18. Do you think your teacher thinks you will ever get into trouble with the law?

Y N DK 19. Are parents to blame if their children get into trouble?

Y N DK 20. Do you think that your mother thinks you will ever get into trouble with the law?

Y N DK 21. If you could start all over again, would you do the same things?

Y N DK 22. Do you think if you were to get into trouble with the law, it would be bad for you in the future?

Y N DK 23. Is it hard for you to have fun when you obey the law and your parents?

Y N DK 24. Have you ever been told that you were headed for trouble with the law?

Y N DK 25. Do you think your friends are good?

Y N DK 26. Have most of your friends been in trouble with the law?

Y N DK 27. Would you rather live somewhere else than at your home?

O S N 28. Do you confide in your father? (Circle "O" for often; "N" for Never; "S" for sometimes).

O S N 29. Do you think there is much fighting at home? (Circle "O" for Often; "N" for Never; "S" for Sometimes).

O S N 30. Do your parents punish you? (Circle "O" for Often; "N" for Never; "S" for Sometimes).

31. If you were real honest about yourself, would you say that you feel you are better than most______as good as most______worse than most______? (Put an "X" in the right space.)

32. Do you think you are quiet______, average______, active______? (Put an "X" in the right space.)

APPENDIX III

EXPERIMENTAL GROUP

RAW DATA

Assembled from the Completed Questionnairs

MALES	FEMALES

PART I: Identifying Information

1. Sex of respondent:

MALES	FEMALES
(20) Male	(14) Female

2. Race

MALES	FEMALES
(17) Negro	(12) Negro
(3) White	(2) White

3. Ages

MALES	FEMALES
(1) 14	(2) 14
(1) 15	(2) 15
(2) 16	(2) 16
(3) 17	(3) 17
(5) 18	(4) 18
(8) 19	(1) 19

4. Marital Status

MALES	FEMALES
(18) Single	(10) Single
(2) Married	(1) Married
(0) Divorced	(1) Divorced
(0) Widowed	(0) Widowed
(0) Separated	(2) Separated

5. Respondents were living with:

MALES	FEMALES
(5) Both parents	(3) Both Parents
(7) One parent	(5) One parent
(7) Relative	(1) Relative
(0) Husband or wife	(1) Husband or wife
(0) Alone	(3) Alone
(1) Other common law wife	(1) Other Childrens Center

6. Motivation for coming to the clinic

MALES	FEMALES
(16) Of your own free will	(3) Of your own free will
(1) Sex partner's request	(6) Sex partner's request
(1) Friend's advice	(1) Friend's advice
(0) Health Department	(1) Health Department
(1) Juvenile Court	(2) Juvenile Court
(0) Parents brought you	(1) Parents brought you
(0) Other Uncle	(0) Other

7. Religious Preference

MALES	FEMALES
(3) Protestant	(3) Protestant
(5) Catholic	(1) Catholic
(0) Jewish	(0) Jewish
(11) Baptist	(10) Baptist
(1) No preference	(0) No preference
(0) Other	(0) Other

	MALES	FEMALES
8. Highest grade in school completed:		
	(1) 7	(0) 7
	(5) 8	(2) 8
	(1) 0	(6) 9
	(9) 10	(4) 10
	(2) 11	(2) 11
	(2) 12	
9. Age respondents quit school or plan to quit:		
	(10) 14	(4) 14
	(0) 15	(1) 15
	(7) 16	(3) 16
	(0) 17	(5) 17
	(2) 18	(1) 18
	(0) 19	
	(1) 20	
10. Employment		
	(4) Full-time	(0) Full-time
	(1) Part-time	(1) Part-time
	(15) Not working	(13) Not working
11. Type of work:		
	(5) Unskilled	(1) Unskilled
12. Where respondents eat supper:		
	(16) At home with family	(11) At home with family
	(2) At home alone	(3) At home alone
	(2) Out with friends	(0) Out with friends
	(0) Out alone	(0) Out alone
13. Number of respondents close friends:		
	(2) 1	(3) 1
	(3) 2	(0) 2
	(5) 3	(4) 3
	(1) 4	(1) 4
	(0) 5	(2) 5
	(1) 6	(0) 6
	(0) 7	(0) 7
	(0) 8	(0) 8
	(8) 9 or more	(3) 9 or more
	(0) none	(1) none

MALES FEMALES

14. Sex of their friends:

MALES	FEMALES
(7) Male	(4) Male
(2) Female	(3) Female
(11) about equally divided	(7) about equally divided

15. Most of their friends were:

MALES	FEMALES
(0) younger than them	(0) younger than them
(3) older than them	(5) older than them
(17) near their age	(9) near their age

16. Spare time activities checked (MALES)

	WEEKDAYS		WEEKENDS		TOTAL
ACTIVITY	AFTERNOON	EVENING	SATURDAY	SUNDAY	
WORK	6	2	3	3	14
MOVIES			4	3	7
GO OUT WITH STEADY	5	1	1	1	8
ACTIVITY CLUB	2	0	1	1	4
BASKETBALL	3	4	4	1	12
SHOOT POOL OR BOWL	3	4	5	1	13
GO DRIVING	2	2	2	2	8
DANCING	2	3	7	2	14
GO TO TAVERN OR BAR		3	3	2	8
PLAY CARDS	6	5	3	3	17
GO OUT WITH PICKUP	2	1	2	1	6
WATCH TV	7	9	4	3	23
HOMEWORK	4	5	2	2	13
READ	3	4	1	3	11
CHURCH	1	1	1	8	11
GO OUT WITH DATE	2	2	8	1	13
MEET WITH GANG	1	1	1		3
GO TO DRUGSTORE	1	1			2
DO WORK ABOUT THE HOUSE	6	4	6	3	19

16. Spare time activities checked FEMALES

ACTIVITIES	WEEKDAYS		WEEKENDS		TOTAL
	AFTERNOON	EVENING	SATURDAY	SUNDAY	
WORK	2	1	1	0	4
MOVIES	2	1	2	3	8
GO OUT WITH STEADY	2	3	4	1	10
ACTIVITY CLUB					
BASKETBALL	1				1
SHOOT POOL OR BOWL	1				1
GO DRIVING		1		1	2
DANCING	3	2	2		7
TAVERN OR BAR	1	2	1	2	6
PLAY CARDS	4	4	4	2	14
GO OUT WITH PICK UP	1	1		1	3
WATCH TV	10	8	5	4	27
HOUSE WORK	4	1			5
READ	7	3	1	2	13
CHURCH	2	1		9	12
GO OUT WITH DATE	2	1	6	1	10
MEET WITH GANG	2	2	2	3	9
GO TO DRUGSTORE	1	1			2
DO WORK ABOUT THE HOUSE	10	6	7	5	28

PART III Sexual knowledge and attitudes

17. Source of sex knowledge

MALES	FEMALES
(2) Parents	(7) Parents
(1) Other adults	(2) Other adults
(2) School	(5) School
(11) Friends	(10) Friends
(3) Books or magazines	(5) Books or magazines
(4) Other <u>experience - brother</u>	(1) <u>Girls at dependent home</u>

18. Age at first sexual intercourse:

MALES	FEMALES
(1) 6 yrs.	(2) 10 yrs.
(1) 8 yrs.	(1) 11 yrs.
(1) 9 yrs.	(2) 12 yrs.
(4) 12 yrs.	(1) 13 yrs.
(3) 13 yrs.	(2) 14 yrs.
(4) 14 yrs.	(4) 15 yrs.
(5) 15 yrs.	(1) 16 yrs.
(1) No answer	(1) 17 yrs.

19. Partner's Age:

MALES	MALES	FEMALES
(1) 8 yrs.	(2) 16 yrs.	(1) 12 yrs.
(1) 9 yrs.	(1) 17 yrs.	(1) 13 yrs.
(1) 10 yrs.	(1) 20 yrs.	(4) 15 yrs.
(1) 11 yrs.	(7) Don't know	(2) 16 yrs.
(3) 12 yrs.		(2) 18 yrs.
(1) 14 yrs.		(1) 20 yrs.
(1) 15 yrs.		(1) 29 yrs.

20. Usual place of sexual intercourse:

MALES	FEMALES
(1) In a car	(1) In a car
(9) In their home	(8) In their home
(5) In partner's home	(3) In partner's home
(2) At other homes	(0) At other homes
(1) In hotels or motels	(2) In hotels or motels
(1) Outdoors	(0) Outdoors
(1) Some other place	(0) Some other place

21. Sexual activity was with:

MALES	FEMALES
(0) Males only	(14) Males only
(16) Females only	(0) Females only
(4) Both	(0) Both

22. Money involved?

MALES	FEMALES
(3) Yes (Usually)	(0) Yes (Usually)
(17) No	(11) No
(0) Sometimes	(3) Sometimes

23. Reason for sexual intercourse:

MALES	FEMALES
(1) Everybody else is doing it	(0) Everybody else is doing it
(1) For money	(0) For money
(1) To be liked	(0) To be liked
(1) To keep my steady	(1) To keep my steady
(14) I enjoy it	(5) I enjoy it
(0) To be popular	(0) To be popular
(4) Don't know	(6) Don't know
(0) Other reason	(2) To hare forth children; It's natural

24. Sexual activities outside marriage conflict with:

MALES	FEMALES
(6) Religious beliefs	(5) Religious beliefs
(2) Parents' beliefs	(5) Parents' beliefs
(0) Friends' beliefs	(0) Friends' beliefs
(10) None of these	(6) None of these
(2) Other	(0) Other

25. Number of different sex partners in a month:

MALES	FEMALES
(4) 1	(11) 1
(3) 2	(2) 2
(5) 3	(1) 3
(3) 4	(0) 4
(1) 5	(0) 5
(1) 6	(0) 6
(0) 7	(0) 7
(1) 8	(0) 8
(0) 9	(0) 9
(0) 10	(0) 10
(1) 11	(0) 11
(1) 12	(0) 12
(0) 13	(0) 13
(0) 14	(0) 14
(0) 15 or more	(0) 15 or more

26. Sexual intercourse is usually with:

MALES	FEMALES
(7) Steady	(11) Steady
(8) Date	(0) Date
(1) Wife or husband	(2) Wife or husband
(3) Pick up	(0) Pick up
(1) Other _sister_	(1) Other _brother_

27. Consumption of alcoholic beverages prior to sexual intercourse?

MALES	FEMALES
(3) Usually	(1) Usually
(7) Sometimes	(3) Sometimes
(2) Hardly ever	(2) Hardly ever
(8) Never	(8) Never

MALES	FEMALES

28. Frequency of sexual intercourse in a month:

MALES	FEMALES
(1) 1	(2) 1
(6) 2	(1) 2
(1) 3	(3) 3
(3) 4	(2) 4
(2) 5	(1) 10
(1) 7	(2) 12
(1) 8	(1) 22
(1) 10	(2) No answer
(1) 12	
(1) 20	
(2) No answer	

29. Enjoyment of sexual intercourse:

MALES	FEMALES
(6) Always	(2) Always
(5) Usually	(3) Usually
(9) Sometimes	(7) Sometimes
(0) Hardly ever	(2) Hardly ever
(0) Never	(0) Never

PART IV Venereal Disease - Knowledge and Attitudes:

30. Following checked as venereal diseases:

MALES	FEMALES
(1) No answer	(1) No answer
(10) Syphilis	(11) Syphilis
(7) Crabs	(2) Crabs
(0) Fever blisters	(3) Fever blisters
(14) Gonorrhea	(10) Gonorrhea
(1) Diarrhea	(2) Diarrhea
(9) Clap	(7) Clap

31. Sources of venereal diseases:

MALES	FEMALES
(1) No answer	(1) No answer
(6) Toilet seat	(8) Toilet seat
(1) Doorknob	(1) Doorknob
(6) Kissing	(4) Kissing
(1) Petting	(0) Petting
(0) Shaking hands	(0) Shaking hands
(15) Sexual intercourse	(12) Sexual intercourse

32. Friends' reaction when they learn they have been exposed to venereal disease:

MALES	FEMALES
(10) Great concern or fear	(11) Great concern or fear
(6) Some concern	(2) Some concern
(4) Wouldn't think much of it	(1) Wouldn't think much of it

33. After a person definitely finds out he has venereal disease it is his duty to tell:

MALES	FEMALES
(8) steady sex person	(8) steady sex person
(3) best friend	(0) best friend
(6) parents	(6) parents
(10) any person he or she has had sexual intercourse with recently	(10) any person he or she has had sexual intercourse with recently
(1) no one	(0) no one
(1) other person doctor	(0) other person

34. Reason given for contracting venereal disease?

MALES	FEMALES
(9) Lack of protection	(6) Lack of protection
(2) Unlucky	(3) Unlucky
(9) New sex partner	(3) New sex partner
(3) Drunk	(0) Drunk
(2) Other reason (out with someone who had it; strain)	(6) Other reason

35. Number of prior treatments for venereal disease:

MALES	FEMALES
(8) 0	(8) 0
(7) 1	(1) 1
(1) 2	(4) 2
(1) 4	(1) 3
(1) 5	
(1) 6	
(1) 8	

36. Learned of clinic from:

MALES	FEMALES
(0) Health officer	(1) Health officer
(13) Friends	(3) Friends
(6) Parents	(4) Parents
(1) Sex partner	(6) Sex partner
(1) Juvenile court	(2) Juvenile court
(1) Other brother	(1) Other

37. When a person thinks he might have venereal disease he usually would seek advice first from:

MALES	FEMALES
(6) Parents	(3) Parents
(4) Close friend	(1) Close friend
(0) Sex partner	(1) Sex partner
(0) Preacher	(0) Preacher
(0) Druggist	(0) Druggist
(9) Doctor or clinic	(9) Doctor or clinic
(2) Other Don't need any advice	(0) Other

MALES	FEMALES

38\. Would like to be able to talk freely to someone you could trust about this problem:

MALES	FEMALES
(13) Yes	(11) Yes
(1) No	(0) No
(6) Don't know	(3) Don't know

39\. It is possible to catch venereal disease from:

MALES	FEMALES
(0) Males only	(4) Males only
(5) Females only	(0) Females only
(13) Either	(5) Either
(2) Don't know	(5) Don't know

40\. Most persons exposed to venereal disease try to hide it from:

MALES	FEMALES
(3) Parents	(7) Parents
(10) Friends	(5) Friends
(2) Sex partner	(1) Sex partner
(1) No one	(0) No one
(7) Everyone	(5) Everyone
(0) Other	(1) Other

41\. One can get a venereal disease again once he has had it?

MALES	FEMALES
(15) yes	(9) Yes
(1) No	(0) No
(4) Don't know	(5) Don't know

42\. Gonorrhea or "clap" is caused by strain as in lifting a heavy object:

MALES	FEMALES
(5) Yes	(2) Yes
(7) No	(6) No
(8) Don't know	(6) Don't know

43\. One can tell by looking at a person if he or she has a venereal disease:

MALES	FEMALES
(2) Yes	(1) Yes
(12) No	(10) No
(6) Don't know	(3) Don't know

44\. One can be born with syphilis?

MALES	FEMALES
(8) Yes	(6) Yes
(5) No	(1) No
(7) Don't know	(7) Don't know

MALES	FEMALES

45. A quick cure for venereal diseases can be bought in a drug store.

MALES		FEMALES	
(4)	Yes	(0)	Yes
(6)	No	(7)	No
(10)	Don't know	(7)	Don't know

BIBLIOGRAPHY

Books

Downie, N. M., Heath, R. W., Basic Statistical Methods. New York: Harper & Row, Inc., 1959.

Garrett, Henry E., Statistics in Psychology and Education. New York: Lngmans, Green & Co., 1961.

Goode, William J., Hatt, Paul K., Methods in Social Research. New York: McGraw-Hill Book Co., Inc., 1952.

Hays, William L., Statistics for Psychologist. New York: Rinehart & Winston, 1964.

Kinsey, Alfred C., et al. Sexual Behavior In the Human Female. Philadelphia: W. B. Saunders Co., 1953.

Polansky, Norman A., (ed.), Social Work Research. Chicago: The University of Chicago Press, 1960.

Selltiz, Jahoda, Deutsch, Cook, Research Methods in Social Relations. United States of America: Holt, Rinehart and Winston, Inc., 1963.

Articles and Periodicals

Ball, John C. and Niel Logan. "Early Sexual Behavior of Lower-Class Delinquent Girls." The Journal of Criminal Law, Criminology and Police Science. Vol. 51, No. 2, July-August, 1960.

Beeston, John, M.D., "Some Psycho-Social Aspects of Venereal Disease", California's Health, Vol. 21, No. 11, December 1, 1963.

Bird, Robert S. "VD is Still a Teenage Problem." Parents Magazine, October, 1959.

Deitche, John H., "The Performance of Delinquent and Non-Delinquent Boys on the Tennessee Department of Mental Health Self-Concept Scale." (Dissertation Abstracts, Vol. XX, No. 4, October 1959.)

Deschin, Celia S., "Teenagers and Venereal Disease; A Sociological Study." American Social Health Association. New York: (Reprinted by the United States Department of Health, Education, and Welfare) Public Health Service Branch, Atlanta, Ga.

Deschin, Celia S., "VD and the Adolescent Personality", The American Journal of Nursing, Vol. 63, No. 11, November 1963.

Epstein, Elenor, M. "The Self-Concept of the Delinquent Female", Smith College Studies. Vol. 32.

Fiumara, Shingert, Byrne, and Fountaine, "An Outbreak of Gonorrhea and Early Syphilis in Mass.", New England Journal of Medicine, Boston: May 23, 1957.

Milner, Ester, "The Effects of Sex Role and Social Status on Early Adolescent Personality", Genetic Psychology Monograph. (Vol. 40, 2nd half). The Journal Press, Provincetown, Mass, November, 1949.

Perlman, Helen Harris, "Identity Problems, Role and Casework Treatment", Social Service Review, Vol. 37, No. 3. September, 1963.

Purcell, John F., "Expressed Self-Concept and Adjustment in Sexually Delinquent and Non-Delinquent Girls". Dissertation Abstracts, Vol. 22. July-September, 1961.

Reckless, Walter, et al. "The SELF-Concept as an Insulator Against Delinquency", American Sociological Review, Vol. 21, No. 6. December, 1956.

Richman, T. Leroy, Venereal Disease. Old Plague-New Challenge. Public Affairs Pamphlet No. 292, New York.

Safier, B., Corrigan, H., Fein, E., and Bradway, K., A Psychiatric Approach to the Treatment of Promiscuity, American Social Hygiene Association, New York, 1949.

Taylor, Susan Dagget, "Clinic for Adolescents with Venereal Disease", The American Journal of Nursing, Vol. 63, No. 11, November, 1963.

Terry, Luther, "VD's Alarming Comeback", Look Magazine. Cowles Magazines and Broadcasting, Inc., December 4, 1962.

Interaction of "VD and Other Social Problems", Youth Board News, New York, May, 1959.

Venereal Disease Education, A Guide for Teachers, Kansas State Board of Health, 1962.

Government Document

U. S. Department of Health, Education and Welfare, A Task Force Report to the Surgeon General. The Eradification of Syphilis, 1960.

Other Sources

Encyclopedia Britannica, Vol. 23, pp. 40-47. 1965.

Information obtained from Dr. L. Clare, Director of the Specialty Clinic, 340 East Madison, Louisville, Kentucky, October 8, 1964.